ARIZONA DEPARTMENT OF HEALTH SERVICES
ARIZONA STATE HOSPITAL

2500 E. VAN BUREN ST.
PHOENIX, ARIZONA 85008
TELEPHONE: (602) 220-6120
FAX: (602) 220-6355

PATIENT DATA:

PATIENT NAME:
DOB: **AGE:** **GENDER:**
RACE:
KNOWN ALIAS:
COUNTY OF COMMITMENT:
CURRENT LEGAL STATUS:
SOCIAL SECURITY NUMBER:
CITIZENSHIP:
BIRTHPLACE:
CITY: **STATE:** **COUNTRY:**

DEMOGRAPHIC INFORMATION:

CURRENT SETTING: Choose an item.
FACILITY NAME:
ADDRESS:
CITY: **STATE:** **ZIP CODE:**
IF INPATIENT, DATE OF CURRENT ADMISSION:

COMMUNITY CONTACTS:

NOTE: If additional community contacts are involved in the patient's care, please complete *Community Contacts Addendum*.

RBHA/TRHBA AFFILIATION:
ADDRESS:
CITY: **STATE:** **ZIP CODE:**
PHONE: **FAX:** **EMAIL:**

ASSIGNED PROVIDER/AGENCY:
CASE MANAGER NAME:
ADDRESS:
CITY: **STATE:** **ZIP CODE:**
PHONE: **FAX:** **EMAIL:**

TREATING BEHAVIORAL HEALTH MEDICAL PROFESSIONAL:
ADDRESS:
CITY: **STATE:** **ZIP CODE:**
PHONE: **FAX:** **EMAIL:**

GUARDIAN NAME:
TYPE OF GUARDIAN (i.e., Title 14+, Title 14, etc.):
ADDRESS:
CITY: **STATE:** **ZIP CODE:**
PHONE: **FAX:** **EMAIL:**

OTHER AGENCIES INVOLVED (i.e., DDD, Probation, etc):
ADDRESS:
CITY: **STATE:** **ZIP CODE:**
PHONE: **FAX:** **EMAIL:**

SPOUSE/SIGNIFICANT OTHER:
RELATIONSHIP:
ADDRESS:
CITY: **STATE:** **ZIP CODE:**
PHONE: **EMAIL:**

LEGAL INFORMATION:

Title 14+ Guardian ☐ **Title 36-540 COT** ☐ **Title 14 Guardian** ☐ **N/A** ☐

CURRENT COT INFORMATION:

COUNTY:
DATE OF ORDER:
 # OF INPATIENT DAYS ORDERED: **# INPATIENT DAYS REMAINING (must be at least 45):**

COT ORDERED FOR: DTS ☐ DTO ☐ PAD ☐ GD ☐
ORDERED 25 DAYS MANATORY LOCAL? YES ☐ NO ☐
CURRENT COT IS ATTACHED: YES ☐ NO ☐
IS THERE A VICTIM NOTIFACATION ON FILE? YES ☐ NO ☐
If yes, complete the following contact information
NAME:
ADDRESS:
CITY: **STATE:** **ZIP CODE:**
PHONE: **EMAIL:**
DOES PATIENT HAVE A CRIMINAL HISOTRY? IF YES, PLEASE PROVIDE DETAILED CRIMINAL HX INCLUDING OUTSTANDING CHARGES:

BENEFIT/ENTITLEMENT STATUS:

MEDICAL HEALTH PLAN NAME:
ID #:
MEDICARE A or B ELIGIBLE? YES ☐ NO ☐
If yes, Medicare D enrolled? YES ☐ NO ☐
NAME OF THE PLAN:
IS THE PATIENT SMI? YES ☐ NO ☐

PSYCHIATRIC INFORMATION:

DOES THE INDIVIDUAL HAVE A HISTORY OF AWOL/ESCAPE FROM ANY INPATIENT FACILITY? IF YES, DESCRIBE:

REASON FOR REFERRAL/JUSTIFICATION FOR ADMITTANCE TO AZSH:

PLEASE PROVIDE A DETAILED TIMELINE OF THE TREATMENTS THAT HAVE BEEN UTILIZED WITHIN PAST 5 YEARS. INCLUDE DATES OF HOSPTIALIZATIONS/INCARCERATION, SYMPTOMS AND BEHAVIORS OF THE PATIENT, AND ANY OTHER PERTINENT INFORMATION:

CURRENT DIAGNOSIS (Utilizing DSM V):

PREVIOUS PSYCHIATRIC DIAGNOSES:

CURRENT PSYCHIATRIC MEDICATIONS WITH DOSAGES:

PERTINENT PSYCHIATRIC MEDICATIONS THAT HAVE BEEN UTILZED IN PAST 5 YEARS:

PLEASE DESCRIBE THE PATIENT'S PSYCHIATRIC BASELINE:

SUBSTANCE USE HISTORY:

YES ☐ NO ☐

If yes, please provide a list of substances used, last known date of use, frequency of use, and how long patient used the substance:

MEDICAL INFORMATION:

ALLERGIES:

CURRENT MEDICAL DIAGNOSES:

PERTINENT PREVIOUS MEDICAL DIAGNOSES:

CURRENT NON-PSYCHIATRIC MEDICATIONS WITH DOSAGES:

PERTINENT PREVIOUS NON-PSYCHIATRIC MEDICATIONS:

CURRENT MEDICAL TREATMENTS BEING UTILIZED:

PERTINENT PAST MEDICAL TREATMENTS THAT HAVE BEEN UTILIZED:

IS THERE AN ACTIVE INFECTION FOR WHICH TREATMENT SHOULD START, CONTINUE, OR CHANGE?
YES ☐ NO ☐

If yes, give specific information related to active infection:

ARE THERE ANY ACUTE MEDICAL PROBLEMS BEYOND STATE HOSPTIAL SCOPE? YES ☐ NO ☐

If yes, please explain:

DATE OF LAST TB SKIN TEST ADMINISTRATION: RESULT:

REASON FOR REFFERRAL TO AZSH:

DESCRIBE THE SYMPTOMS, DEFICITS, SPECIFIC IMPAIRMENTS, AND BEHAVIORS THAT ARE CURRENTLY PREVENTING TREATMENT IN THE COMMUNITY:

DESCRIBE THE EFFORTS MADE TO PROVIDE TREATMENT OUTSIDE THE STATE HOSPITAL IN LESS RESTRICTIVE ALTERNATIVE SETTINGS:

DESCRIBE THE REASONS WHY THE EFFORTS FOR TREATMENT OUTSIDE THE STATE HOSPTIAL WERE UNSUCCESSFUL:

DESCRIBE THE REASONS WHY THE STATE HOSPITAL IS THE LEAST RESTRICTIVE SETTING FOR THE PATIENT:

WHAT ARE THE EXPECTED BENEFITS OF THE PATIENT RECEIVING TREATMENT AT THE STATE HOSPITAL?

ESTIMATED LENGTH OF STAY AT AZSH:

PROPOSED TREATMENT GOALS:

IDENTIFY THREE GOALS THAT THE PATIENT SHOULD DEMONSTRATE PRIOR TO BEING DISCHARGED FROM AZSH:
Note: The goals must be realistic, achievable, and measurable for the patient.

1.
2.
3.

Email completed application and copy of current COT to Admissions.Office@azdhs.gov

COMMUNITY CONTACTS ADDENDUM

NAME & RELATION TO PATIENT:
ADDRESS:
CITY: **STATE:** **ZIP CODE:**
PHONE: **FAX:** **EMAIL:**

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ARIZONA STATE HOSPTIAL ADMISSION WORKFLOW

- ☐ Complete Arizona State Hospital Admission Application including attaching current COT.
- ☐ Email completed Application and copy of current COT to Admissions.Office@azdhs.gov

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IF APPLICATION IS ACCEPTED

- ☐ Gather the following required documentation and email to AzSH's Admission Office at admissions.Office@azdhs.gov
  - ☐ T/RBHA LOA (Letter of Authorization/Intent to Treat)
  - ☐ RBHA enrollment verification
  - ☐ Most current history & physical
  - ☐ Psychiatric Assessment/Evaluation—Most Current
  - ☐ Psychosocial Assessment/Evaluation—Most Current
  - ☐ Current Psychological Assessment (include Risk Assessment if completed within last year)
  - ☐ Current Individual Treatment Plan
  - ☐ Current Functional Analyses and Behavioral Plans (if applicable)
  - ☐ Last Two (2) weeks only of Progress Notes (All Disciplines)
  - ☐ Current Medication Administration (2 weeks only)
  - ☐ Laboratory and other testing in past 30 days (CBC w/diff, complete chemistry profile and urinalysis are required for admission with past 30 days)
  - ☐ Quantiferon TB test administered at least 30 days prior to admission.
  - ☐ Current Negative COVID-19 Test
  - ☐ Completion of Infectious Disease Screening Form
  - ☐ Copy of client's Proof of Residency
  - ☐ Copy of client's Social Security Card
  - ☐ Completed copy of Payor Financial (see attached)
  - ☐ Copy of client's AHCCC/Medicare Card or other insurance cards (if applicable)

    OR

    - ☐ PNMIS AHCCCS/Title XIX proof of eligibility or application submission verification (include plan name and #)
    - ☐ PMMIS Medicare A, B, & D eligibility (include plan name and member #)

  - ☐ Current Legal Documents (including guardianship paperwork)
  - ☐ Victim Notification (if applicable)
  - ☐ Order for Transport and/or Change of Venue to Maricopa County
  - ☐ If the patient is in jail, ALL jail records are required
- ☐ Arrange with AzSH Admission Office for scheduled Admission Date
- ☐ On day of admission to AzSH, AzSH needs the following documents:
  - ☐ Discharge Summary/Assessment from placement
  - ☐ Last Two (2) weeks of progress notes (All Disciplines)
  - ☐ Updated Medical Administration (2 weeks only)
  - ☐ T/RBHA CON (Certificate of Need dated for the day of admission) with admission DSM V diagnosis code

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IF APPLICATION IS REJECTED

- ☐ Follow outlined procedure contained within the rejection letter.

ASH Admission Portal

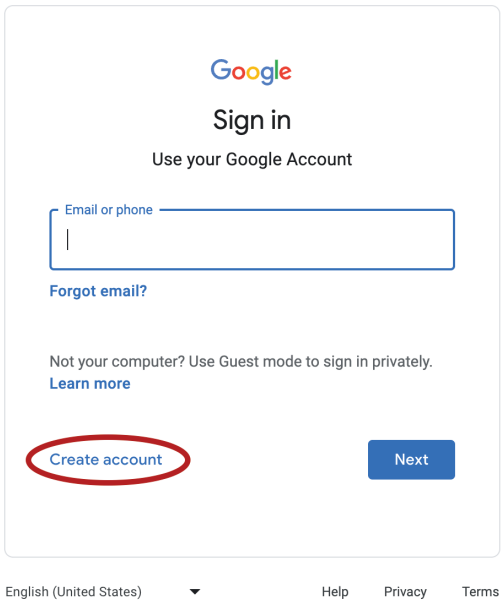
https://ash.azdhs.gov/ASHAdmissionPortal/

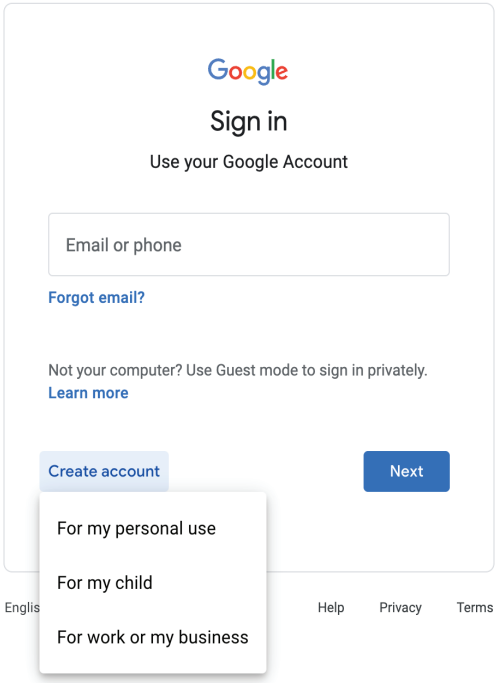
Registering for the new portal

Staff will need to have a Google account in order to use the new portal. We recommend that staff use their work email, and complete the enrollment process for a google account as follows.

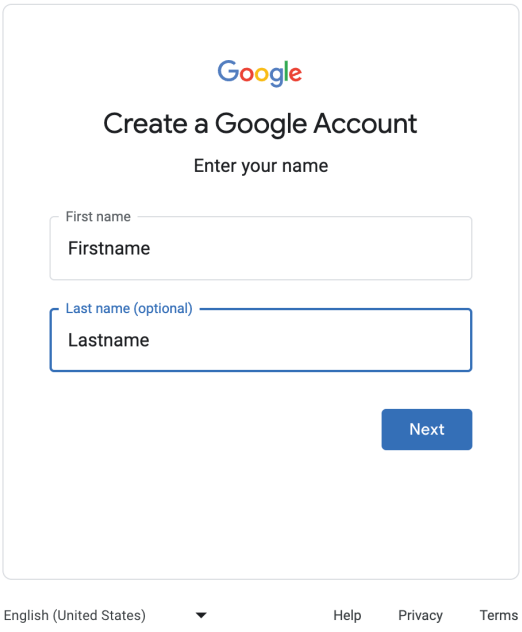
1. Go to the Google Account Signup page: https://accounts.google.com/signin.

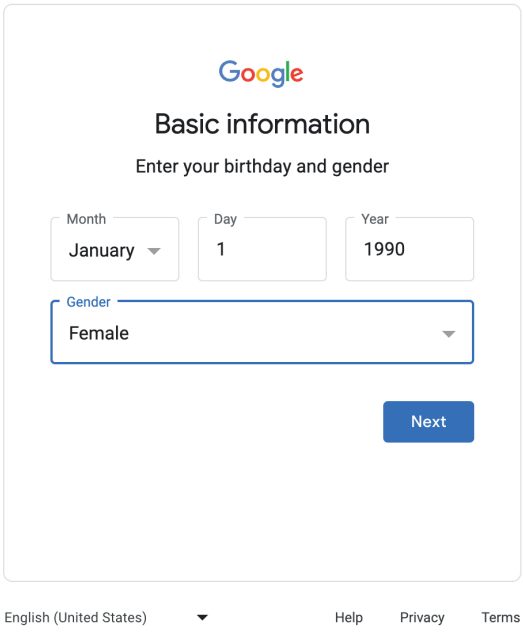
Select **Create account** and then the option **For work or my business**



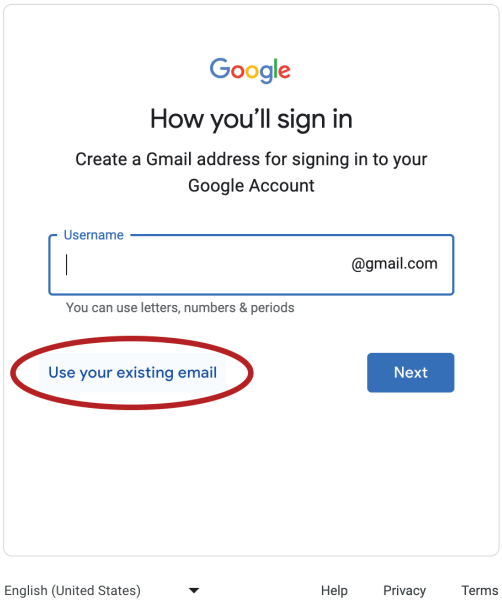


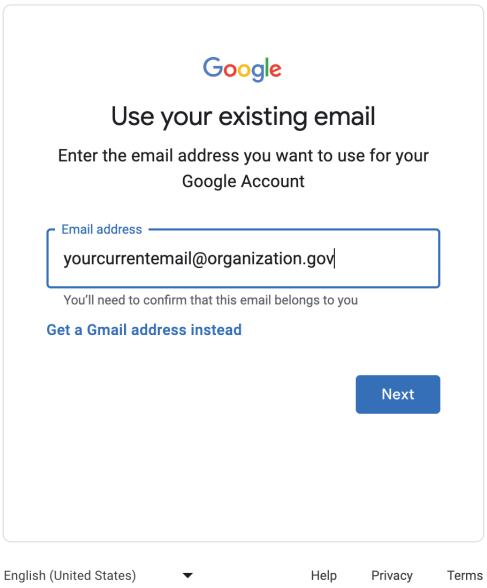
2. Enter your name and date of birth information



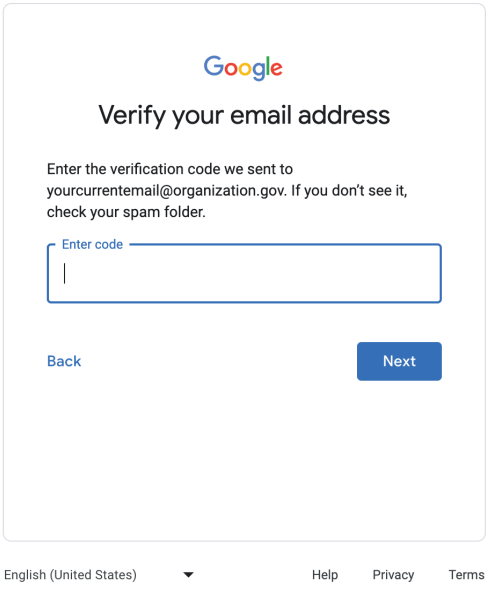


3. When prompted to enter an email address, select **Use your existing email** and enter your work email address.



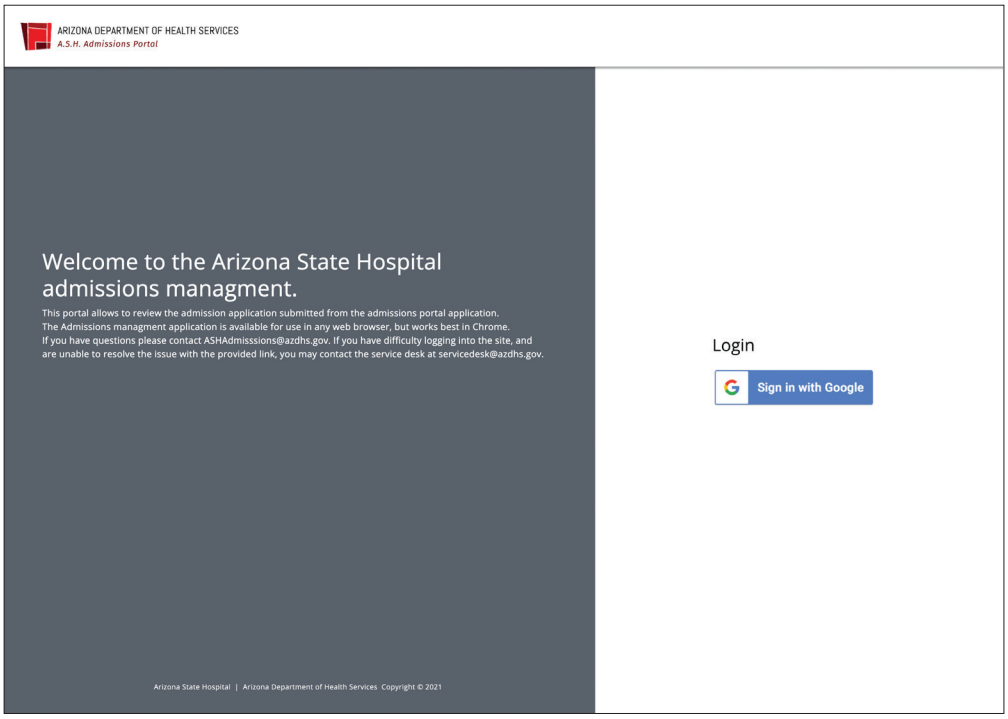


4. You will be prompted to verify your email address. Check your organizational email box and enter the provided verification code.

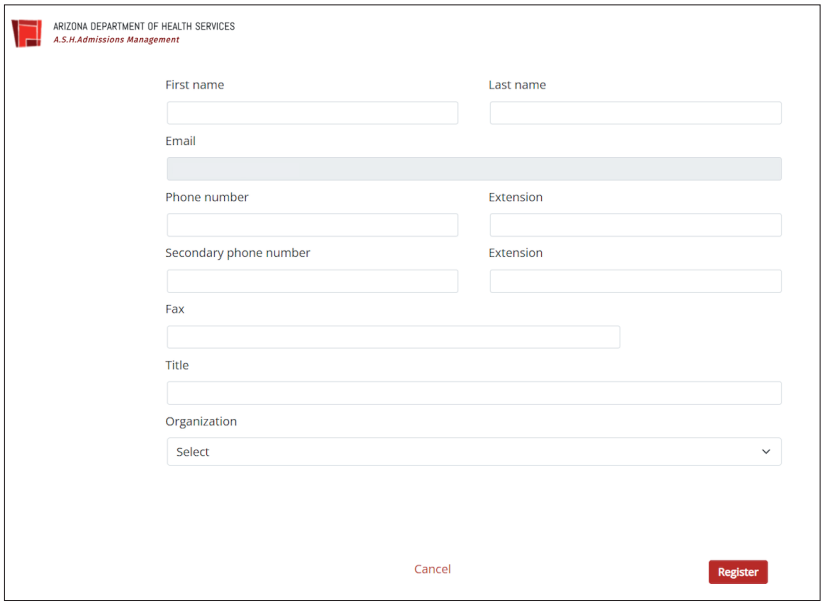


5. You should now be complete with the Google Account Setup. This is a one time setup and you may now proceed to logging into the ASH Admissions Application Portal.

6. Go to the [ASH Admissions Application Portal](). Select **Sign in with Google**. Follow the prompts to log in with your newly created Google Account.



7. Once you are logged in, follow the First Time Registration workflow by entering your information, and the organization you work with.



8. You are done! Our admissions team will approve your account as soon as we are able. You will be notified when your account is ready to use.

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Infectious Disease Screening Form

Patient Name:_____

DOB:_____

Please complete & send the following form within one week prior to transfer to Arizona State hospital

1. Does the patient have any travel History or has had exposure to an ill person who traveled Internationally to countries such as West African countries [DRC, Guinea,Liberia etc] in last 21 days? Yes No

2. Does the Patient have any signs or symptoms of communicable disease or history of multidrug resistant organisms? Yes No

3. Does the patient have any of the following symptoms:

Fever of 38C (101 F) or greater	Yes	No
Severe Headache	Yes	No
Muscle pain	Yes	No
Diarrhea	Yes	No
Vomiting	Yes	No
Stomach Pain	Yes	No

Health Professional Information (i.e. physician, nurse, etc.)

Name: _____

Telephone: _____

Signature:_____ Date: _____

ARIZONA DEPARTMENT OF HEALTH SERVICES

ARIZONA STATE HOSPITAL

PAYOR FINANCIAL

NAME		SS#		DOB		MR#	

1. Benefits and Financial Obligations are managed by a Payee: ☐ Yes ☐ No
   Name of Payee:_____ Telephone# :(_____)_____
   Address: _____

2. Do you receive or expect to receive money from any of the following? ☐ Yes ☐ No

Tribal Money	Amount: $_____
Social Security	Amount: $_____
Supplemental Security Income	Amount: $_____
Worker's Comp/Industrial	Amount: $_____
Retirement/Pension	Amount: $_____
Veteran Benefits	Amount: $_____
Spouse's Income	Amount: $_____

3. Do you have any of the following? ☐ Yes ☐ No

Checking	Amount: $_____
Savings Account	Amount: $_____
Current Market Value of Stocks	Amount: $_____
Bonds	Amount: $_____
Mutual Funds	Amount: $_____
Other: _____	Amount: $_____

4. Do you have any of the following Monthly Financial obligations? ☐ Yes ☐ No

Court Fees	Amount: $_____
Child Care	Amount: $_____
Dep. Support	Amount: $_____
Education Expenses	Amount: $_____
Fiduciary Fees	Amount: $_____

Other Obligations: _____ Amount: $_____
(House maintenance, Car payment, Insurance, etc.)

* Proof of deductions must be supported by documentation and verified by the ASH Office of Patient Finance.
* $90.00 for Personal Spending will be added to Monthly Financial Obligation for any patient's with income.

I affirm that the statements made herein are true and correct to the best of my knowledge.

Patient/Guardian/Payee Signature _____ Date _____

Other than patient signature _____ Date _____

Relationship to patient _____

IMPORTANT: This form must be complete and returned in order to make assessment in accordance with the ability to pay. Otherwise, the full charge will be assessed.

ASH Financial Rev: 01/27/16